State Agency – Project Status Report

Reporting Period Ending on October 31, 2013

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Document Information Page

Required Information	Definition
Document:	Alabama Monthly State Agency Status Report
Document ID:	
Version:	0.1
Approval Date:	08/30/2013
Location:	iTRACE
Owner:	HP Enterprise Services
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Approved by:	Clay Gaddis

Amendment History

CR#	Document Version #	Approval Date	Modified By	Section, Page(s) and Text Revised
	0.1	08/30/2013	John Evans	Initial Version.

Upcoming Projects/Status

The projects depicted below represent changes that potentially impact State Agencies:

1. Project/Change Order: Affordable Care Act (ACA) Operating Rules – Phase I and II

1.1 Overview: Affordable Care Act (ACA) Section 1104 requires standards be applied in the eligibility verification response (271) in order to enable the determination of an individual's eligibility benefits and financial responsibility for specific services prior to or at the date of service. Once completed, providers will have the option of viewing all recipient eligibility information (information currently displayed) or specifying certain types of coverage information. Additionally, copayment information will also display for providers. Currently, the eligibility response returns the benefit plan information and limitation information. This information will continue to be returned, but will be modified to accept and process multiple service type codes.

Currently, providers request eligibility verification on a recipient for a given date range in order to determine if a service should be provided. The service type defaults to 30 (Health Benefit Plan Coverage). The eligibility response currently returns benefit plan coverage and limitation information.

The eligibility verification request will be modified to accept and process multiple service type codes, besides 30. The eligibility request date range entered applies to all the service types entered for the request. The user may submit multiple service type codes in the request.

The response will be modified to include additional service type coverage information for the recipient's benefit plan. This is in addition to the existing coverage information being returned today. The response information depends on the service type codes in the request being generic or explicit request type.

A generic inquiry request is defined as a request for eligibility information for the service type – 30 (Health Benefit Plan Coverage). There is a default group of service type codes associated with generic request that will be included in the response.

An explicit inquiry request is defined as a request for eligibility information for any service type other than 30 shown in the explicit list below. So, twelve of the thirteen service type codes in the generic list will be treated as explicit when submitted on the request individually.

The generic and explicit service type codes for the ACA project correspond to codes in the X12 270/271 Implementation Guide for 2110C loop for EB01. The ACA requirements do not include all the codes from the list.

Generic Service Type Codes
The list below shows the service type codes returned on the response when a generic request of 30 is received on the request.

Svc Type Code	Description
1	Medical Care
30	Health Benefit Plan Coverage
33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit -office
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care

Explicit Service Type Codes

The service type codes associated with an explicit request are listed below.

Svc Type Code	Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric Inpatient
A8	Psychiatric Outpatient
AD	Occupational Therapy

Svc Type Code	Description
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

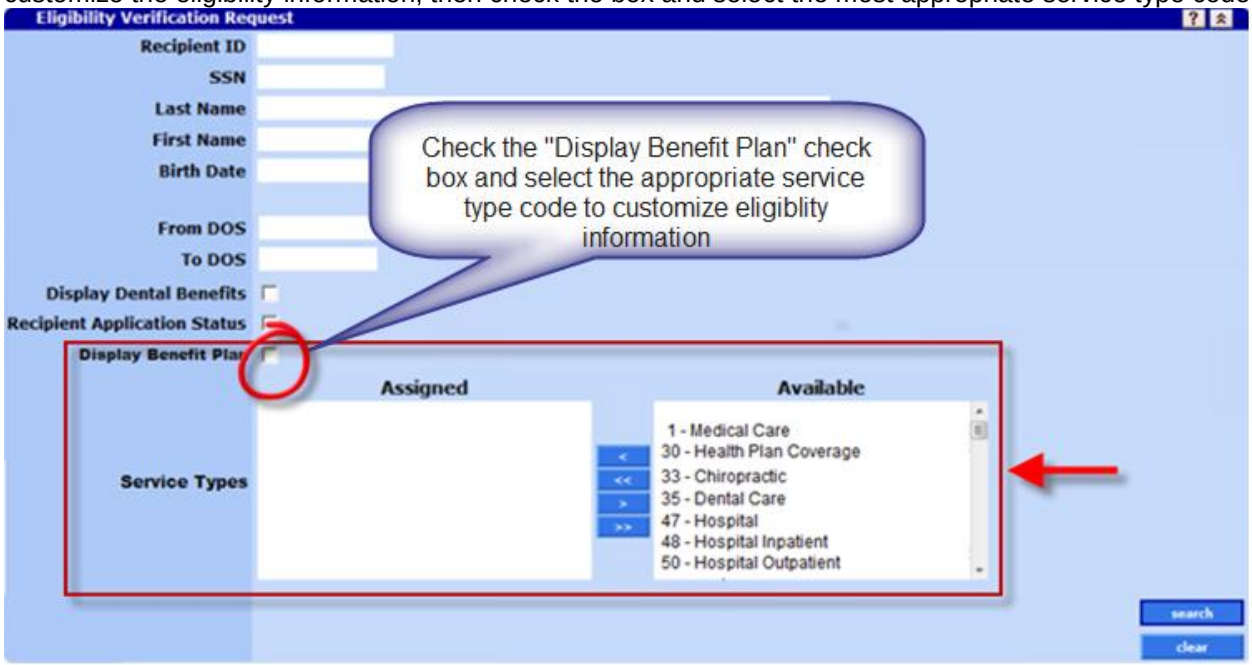
The current eligibility response includes service type codes not found on either generic or explicit ACA lists. We will continue to return these non-ACA codes as we do today.

Svc Type Code	Description	Response for 271
41	Routine (Preventive) Dental	Used for last dental screening
69	Maternity	Used for maternity waiver
71	Audiology Exam	Used for last hearing screening
96	Professional (Physician)	Used for physician lock in
AM	Frames	Used for benefit limits on eye frames and eye fitting
AO	Lenses	Used for benefit limits on eye lenses

The response will also include patient financial responsibility for the service types included in the response. This includes co-insurance, co-pay and deductible for the recipient's benefit plan. A zero amount will be returned for deductible and co-insurance because they do not apply to Alabama benefit plans.

Medicaid Interactive Web Portal Changes

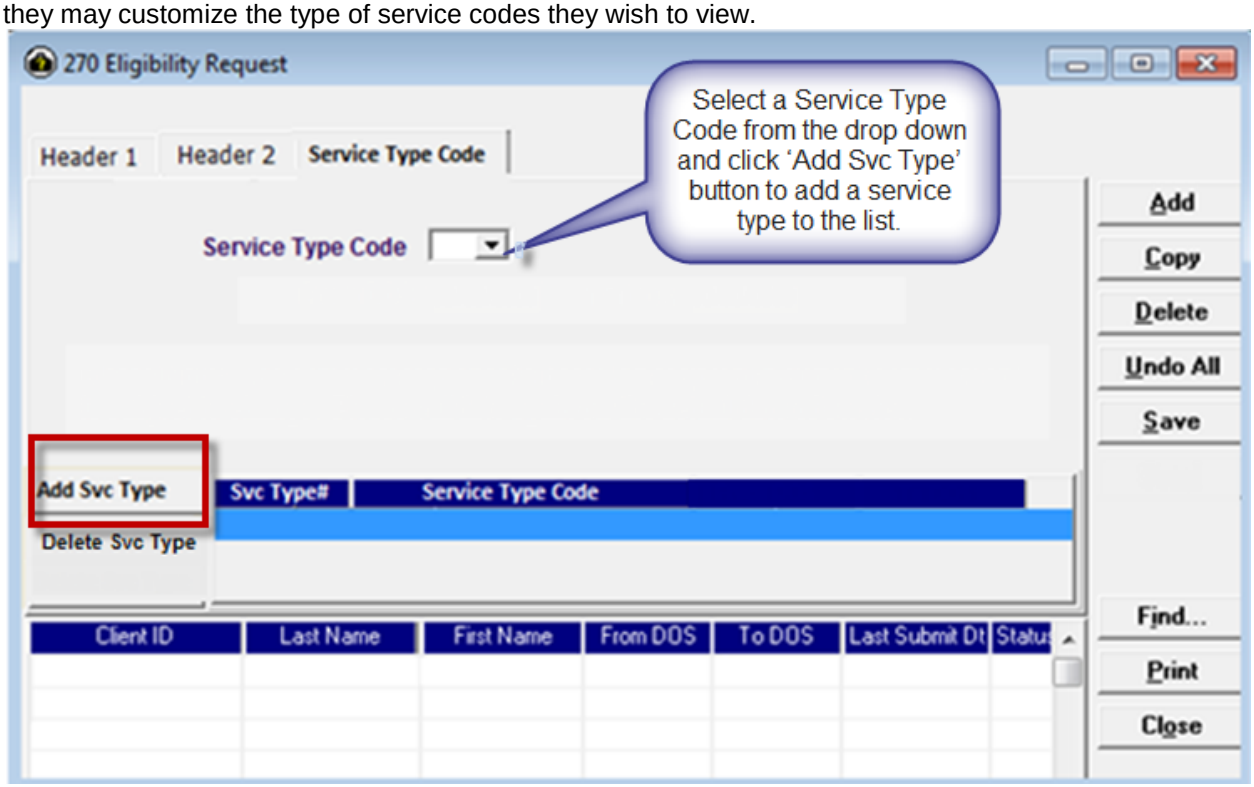
If you use Medicaid's Interactive Web Portal, the following information is changing: Providers will now see additional information displayed on the eligibility verification request panel. (See below). If a provider wants to view all information as they currently do, DO NOT check the box next to 'Display Benefit Plan'. If a provider wants to customize the eligibility information, then check the box and select the most appropriate service type code.



Copayment information will be returned regardless of the service type code selected.

Provider Electronic Solutions Changes

If you use Provider Electronic Solutions to verify eligibility, the following information is changing:
A new “Service Type Code” tab is available on the Eligibility Verification Request form. If a provider does not access this tab during the eligibility process, then ALL information for eligibility will display. If a provider accesses this tab, they may customize the type of service codes they wish to view.



Automated Voice Response System Changes

Providers will be able to select the service type codes they wish to retrieve, or select 30 for information currently displayed.

1.2 Current Status: Changes are in production.

1.3 Potential Impact: Changes to what can be requested on a 270 and what will be returned on a 271.

1.4 Implementation Date: 10/26/2013

2. Project/Change Order: Affordable Care Act (ACA) Operating Rules – Phase III

2.1 Overview: Phase III Operating Rules apply to Claim Payment/Advice (835) transactions, Electronic Funds Transfer (EFT), and Electronic Remittance Advice (ERA) data. Phase III continues to build on the Phase I and II rules. Phase III is made up of the following rules:

Rule 350 – 835 Retrieval (no operational impact to providers)
Enhances Phase II by adding an additional transaction for 835 data file retrieval.

Rule 360 - Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)
Dictates the combination of codes that can be used for certain business scenarios. Working with their members and other large healthcare systems, CAQH CORE defined four common business scenarios that impact claim payment and processing. For each of these scenarios, CAQH CORE broke them down into detail level items and defined a specific code combination that MUST be used by Healthcare Systems on the v5010 X12 835 electronic RA. Business scenarios that are encountered beyond these four are left to the discretion of the Healthcare System to determine the code combination to use.

Rule 370 – EFT and ERA Re-association Rule (CCD+/835)
Standardizes the Re-association Data by specifying the location where the data should be stored in both the CCD+ EFT transaction and the 835 ERA transaction. Specifically, Re-association Data is to be placed in the:

- Addenda Record for the CCD+ transaction
- BPR and TRN Segments of the 835 Transaction

Rule 370 additionally specifies:

- The maximum allowed lag time between receipt of an ERA and its corresponding EFT
- Duration of Dual Delivery of Paper and Electronic versions of the ERA when a provider elects to receive ERAs
- Requirements for resolving late or missing EFTs and/or ERAs

Rule 380-382 - ERA/EFT Enrollment

- Rule specifies the maximum data that may be collected to enroll a provider or trading partner for receiving an Electronic RA (ERA/835) or payments via EFT
- Only data elements specified by the rule may be collected.
- The rule specifies the names of the all data elements. These names must be used exactly on paper or electronic enrollment forms.
- The data elements must be presented in a specific order on paper or electronic forms.
- The rules specify which data elements are mandatory and which are optional.
- Related data elements are put into Data Element Groups. The groups must also be presented in a specific order and may be either mandatory or optional.
- The data elements and data element groups are similar, but not identical, for the two rules.

2.2 Current Status: Work on proposal is in progress. No changes have been made.

2.3 Potential Impact: Additional information will be provided.

2.4 Anticipated Implementation Date: 04/2014

Technology for better business outcomes

4AA2-xxxxENW, August 2012